lations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded.

15.5 **Request for Administrative Review to the Secretary of Human Services pursuant to 33 V.S.A. §909(a)(3)**

(a) No appeal may be taken under this section when the remedy requested is retrospective relief from the operation of a provision of this rule or such other relief as may be outside the power of the Secretary to order. Such relief may be pursued by an appeal to the Vermont Supreme Court or Superior Court pursuant to 33 V.S.A. §909(a)(1) and (2), or prospectively by a request for rulemaking pursuant 3 V.S.A. §806.

(b) Appeals under this section shall be governed by the relevant provisions of the Administrative Procedures Act, 3 V.S.A. §§809-815.

(c) Proceedings under this section shall be initiated by filing two copies of a written Request for Administrative Review, on forms prescribed therefor.

(d) Within 5 days of receipt of the Request, the Director shall forward one copy to the Secretary. Within 10 days thereafter, the Secretary shall designate an independent appeals officer who shall be a registered or certified public accountant. The Letter of Designation shall be served on all parties to the appeal. All documents filed thereafter shall be filed directly with the independent appeals officer and copies served on all parties.

(e) Within 10 days of the designation of an independent appeals officer, the Division shall forward to him or her those materials that represent the documentary record of the Division's action.

(f) Within 30 days thereafter, the independent appeals officer shall, on reasonable notice to the parties, convene a prehearing conference (which may be held by telephone) to consider such matters as may aid in the efficient disposition of the case, including but not limited to:

(1) the simplification of the issues,

(2) the possibility of obtaining stipulations of fact and/or admissions of documents which will avoid unnecessary proof,

(3) the appropriateness of prefiled testimony,

(4) a schedule for the future conduct of the case.

The independent appeals officer shall make an order which recites the action taken at the conference, including any agreements made by the parties.

(g) The independent appeals officer shall hold a hearing, pursuant to 3 V.S.A. §809, on no less than 10 days written notice to the parties, according to the schedule determined at the prehearing conference. The independent appeals officer shall have the power to subpoena witnesses and documents and administer oaths. Testimony shall be under oath and shall be recorded either stenographically or on tape. Prefiled testimony, if admitted into evidence, shall be included in the transcript, if any, as though given orally at the hearing. Evidentiary matters shall be governed by 3 V.S.A. §810.

(h) The independent appeals officer may allow or require each party to file Proposed Findings of Fact which shall contain a citation to the specific part or parts of the record containing the evidence upon which the proposed finding is based. The Proposed Findings shall be accompanied by a Memorandum of Law which shall address each matter at issue.

(i) Within 60 days after the date of the hearing, or after the filing of Proposed Findings of Fact, whichever is the later, the independent appeals officer shall file with the Secretary a Recommendation for Decision, a copy of which shall be served on each of the parties. The Recommendation for Decision shall include numbered findings of fact and conclusions of law, separately stated, and a proposed order. If a party has submitted Proposed Findings of Fact, the Recommendation for Decision shall include a ruling upon each proposed finding. Each party's Proposed Find-

ings and Memorandum of Law shall accompany the Recommendation.

(j) At the time the independent appeals officer makes her or his Recommendation, she or he shall transmit the docket file to the Secretary. The Secretary shall retain the file for a period of at least one year from the date of the Final Determination in the docket. In the event of an appeal of the Secretary's Final Determination to the Vermont Supreme Court or to Superior Court, the Secretary shall make disposition of the file as required by the applicable rules of civil and appellate procedure.

(k) Any party aggrieved by the Recommendation for Decision may file Exceptions, Briefs, and if desired, a written Request for Oral Argument before the Secretary. These submissions shall be filed with the Secretary within 15 days of the date of the receipt of a copy of the Recommendation and copies served on all other parties.

(l) If oral argument is requested, within 20 days of the receipt of the Request for Oral Argument, the Secretary shall arrange with the parties a mutually convenient time for a hearing.

(m) Within 45 days of the receipt of the Recommendation or the hearing on oral argument, whichever is the later, the Secretary shall issue a Final Determination which shall be served on the parties.

(n) A party aggrieved by a Final Determination of the Secretary may obtain judicial review pursuant to 33 V.S.A. §909(a)(1) and (2) and Subsections 15.6 and 15.7 of this Rule.

15.6 **Appeal to Vermont Supreme Court pursuant to 33 V.S.A. §909(a)(1)**

Proceedings under this section shall be initiated, pursuant to the Vermont Rules of Appellate Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

15.7 **Appeal to Superior Court pursuant to 33 V.S.A. §909(a)(2)**

De novo review is available in the Superior Court of the county where the nursing facility is located. Such proceedings shall be initiated, pursuant to Rule 74 of the Vermont Rules of Civil Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

15.8 **Settlement Agreements**

The Director may agree to settle reviews and appeals taken pursuant to Subsections 15.3 and 15.5, and, with the approval of the Secretary, may agree to settle other appeals taken pursuant to 33 V.S.A. §909 and any other litigation involving the Division on such reasonable terms as she or he may deem appropriate to the circumstances of the case.

16 DEFINITIONS AND TERMS

For the purposes of these rules the following definitions and terms are used:

Accrual Basis of Accounting: an accounting system in which revenues are reported in the period in which they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

Agency: the Agency of Human Services.

AICPA: American Institute of Certified Public Accountants.

Allowable Costs or Expenses: costs or expenses that are recognized as reasonable and related to resident care in accordance with these rules.

Ancillary Services: therapy services and therapy supplies, including oxygen, whether or not separate charges are customarily made. Other medical items or services identifiable to a specific resident furnished at the direction of a physician

and for which charges are customarily made in addition to the per diem charge.

Base Year: a calendar year for which the allowable costs are the basis for the case-mix prospective per diem rate.

Case-Mix Weight: a relative evaluation of the nursing resources used in the care of a given class of residents.

Certificate of Need (CON): certificate of approval for a new institutional health service, issued pursuant to 18 V.S.A. §2403.

Certified Rate: the prospective case-mix rate certified by the Division of Rate Setting to the Department of Social Welfare.

Common Control: where an individual or organization has the power to influence or direct the actions or policies of both a provider and an organization or institution serving the provider, or to influence or direct the transactions between a provider and an organization serving the provider. The term includes direct or indirect control, whether or not it is legally enforceable.

Common Ownership: where an individual or organization owns or has equity in both a facility and an institution or organization providing services to the facility.

Cost Finding: the process of segregating direct costs by cost centers and allocating indirect costs to determine the cost of services provided.

Cost Report: a report prepared by a provider on forms prescribed by the Division.

Direct Costs: costs which are directly identifiable with a specific activity, service or product of the program.

Director: the Director of Administrative Services and Rate Setting, Agency of Human Services.

Division: the Division of Rate Setting, Agency of Human Services.

Donated Asset: an asset acquired without making any payment in the form of cash, property or services.

DRI: Data Resources Institute Incorporated's *Health Care Costs, as published by McGraw-Hill,* including national forecasts of hospital, nursing home, and home health agency market baskets and regional forecasts of CPI (All Urban) for food and commercial power and CPIU-All Items.

Facility or nursing facility: a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Vermont.

Fair Market Value: the price an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

FASB: Financial Accounting Standards Board.

Final Order of the Division: an action of the Division which is not subject to change by the Division, for which no review or appeal is available from the Division, or for which the review or appeal period has passed.

Free standing facility: a facility that is not hospital-affiliated.

Funded Depreciation: funds that are restricted by a facility's governing body for purposes of acquiring assets to be used in rendering resident care or servicing long term debt.

Fringe Benefits: shall include payroll taxes, workers' compensation, pension, group health, dental and life insurances, profit sharing, *cafeteria* plans and flexible spending plans, child care for employees, employee parties, and gifts shared by all staff.

Generally Accepted Accounting Principles (GAAP): those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

Generally Accepted Auditing Standards (GAAS): the auditing standards that are most widely recognized in the public accounting profession.

Health Care Financing Administration (HCFA): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Hold Day: a day for which the provider is paid to hold a bed open is counted as a resident day.

Hospital-affiliated facility: a facility that is a distinct part of a hospital provider, located either at the hospital site or within a reasonable proximity to the hospital.

Incremental Cost: the added cost incurred in alternative choices.

Independent Public Accountant: a Certified Public Accountant or Registered Public Accountant not employed by the provider.

Indirect Costs: costs which cannot be directly identified with a particular activity, service or product of the program. Indirect costs are apportioned among the program's services using a rational statistical basis.

Inflation Factor: a factor that takes into account the actual or projected rate of inflation or deflation as expressed in indicators such as the New England Consumer Price Index.

Interim Rate: a prospective Case-Mix rate paid to nursing facilities on a temporary basis.

Legend Drugs: drugs for which a physician's prescription is required by state or federal law.

Look-back: a review of a facility's actual costs for a previous period prescribed by the Division.

Medicaid Resident: a nursing home resident for whom the primary payor for room and board is the Medicaid program.

New England Consumer Price Index (NECPI-U): the New England consumer price index for all urban consumers as published by DRI McGraw-Hill.

OBRA 1987: the Omnibus Budget Reconciliation Act of 1987.

Occupancy Level: the number of paid days, including hold days, as a percentage of the licensed bed capacity.

Per Diem Cost: the cost for one day of resident care.

Prospective Case-Mix Reimbursement System: a method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

Provider Reimbursement Manual, HCFA-15: a manual published by the U.S. Department of Health and Human Services, Health Care Financing Administration, used by the Medicare Program to determine allowable costs.

Rate year: the State's fiscal year ending June 30.

Related organization or related party: an individual or entity that is directly or indirectly under common ownership or control or is related by family or other business association with the provider. Related organizations include but are not restricted to entities in which an individual who directly or indirectly receives or expects to receive compensation in any form is also an owner, partner, officer, director, key employee, or lender, with respect to the provider, or is related by family to such persons.

Resident Assessment Form: Vermont version of a federal form, which captures data on a resident's condition and which is used to predict the resource use level needed to care for the resident.

Resident Day: the care of one resident for one day of services. The day of admission is counted as one day of care, but the day of discharge or death is not. A paid hold day is counted as a resident day.

Restricted Funds and Revenue: funds and investment income earned from funds restricted for specific purposes by donors, excluding funds

restricted or designated by an organization's governing body.

RUGS-III: A systematic classification of residents in nursing facilities based upon a broad study of nursing care time required by groups of residents exhibiting similar needs.

Secretary: the Secretary of the Agency of Human Services.

Specialty nursing facilities: those facilities serving populations with distinct characteristics not generally applicable to nursing facilities.

Standardized Resident Days: Base Year resident days multiplied by the facility's average Case-Mix score for the base year.

State nursing facilities: facilities owned and/or operated by the State of Vermont.

Swing-Bed: a hospital bed used to provide nursing facility services.

17 TRANSITIONAL PROVISIONS

17.1 Special Transitional Rates for Residents of the Vermont State Hospital Nursing Facilities

(a) For residents of Vermont State Hospital Nursing Facilities transferred into another Vermont licensed nursing facility (receiving facility) a special transitional per diem rate is available.

(b) The special transitional rate payable for each transferred resident shall consist of the current per diem rate for the receiving facility as calculated pursuant to Sections 5 to 9 of these rules and a supplemental incentive payment, to help defray the anticipated transitional expense of accommodating the needs of the transferred residents.

(1) Transferred residents shall be grouped into classes by the Department of Developmental and Mental Health Services in consultation with the Division of Licensing and Protection, based on the anticipated difficulty of and resources needed for the transition. The amount of the supplemental payment shall be based on the classification of the resident.

(2) The per diem supplemental payment shall be payable as a lump sum for up to one year from the date of the transfer or to June 30, 1994, whichever period is the shorter, as long as the transferred person remains resident in the facility. Any advance payments for days during which the transferred person is not resident will be treated as overpayments and subject to refund by deductions from the provider's Medicaid payments.

(3) For transferred persons still resident in the receiving facility after June 30, 1994, the per diem supplemental payment will continue to be paid as long as the following criteria are satisfied:

(i) The transferred person continues to reside at the receiving facility.

(ii) The facility documents to the satisfaction of the Division of Licensing and Protection that the transferred resident continues to present significant behavior management problems by exhibiting behaviors that are significantly more challenging than those of the general nursing facility population.

(c) The transferred resident's current case-mix score in the Vermont State Hospital Nursing Facilities (as determined by the Division of Licensing and Protection before transfer) shall be assigned to the transferred resident for two quarters after the transfer and shall be used as the minimum score for that resident in the calculation of the facility's aggregate case-mix score. For subsequent quarters, the score shall be based on normal resident assessment procedures.

(d) To be eligible for a special transitional rate, the receiving facility must have in place a plan of care developed in conjunction with and approved by the Department of Developmental and Mental Health Services and the Division of Licensing and Protection.

17.2 Special Rates for Medicaid Eligible Furloughees of the Department of Corrections

A special rate equal to 110 percent of a nursing facility's ordinary Medicaid rate shall be paid for care provided to Medicaid eligible furloughees of the Department of Corrections.

17.3 Quality Incentives

Certain supplemental payments may be made to nursing facilities providing a superior quality of care in an efficient and effective manner, to be used for facility quality enhancements.

(a) Objective Standards. Supplemental payments will be based on:

(1) objective standards of quality to be determined for the Department of Aging and Disabilities, and

(2) objective standards of cost efficiency determined by the Division.

(b) Supplemental Payments.

(1) The supplemental payments may be made periodically from a quality incentive pool to certain nursing facilities whose operations meet the standards established pursuant to this subsection.

(2) Supplemental payments shall be expended by the provider to enhance the quality of care provided in the facility. In determining the nature of these expenditures, the provider shall consult with the facility's Resident Council.

(c) The quality and efficiency standards established under this subsection, and the method of distribution of the quality incentive pool shall be subject of a notice of practices and procedures issued pursuant to Subsection 1.8(d) of these rules.

17.4 Application of Rule

(a) This rule applies to Medicaid payments made to nursing facilities beginning July 1, 1998, except for the changes to subsection 7.2(a) relating to case-mix categories and weights which shall not apply to rates before January 1, 1999.

(b) The following case-mix classes and weights for all residents irrespective of payor source (except those whose Medicaid payment rates are set pursuant to Section 14) shall continue to be used in the calculation of all Medicaid payment rates for days of service before January 1, 1999:

Class Number	Class Name	Case-Mix Weight
1	RHD Rehab Hi	5.05
2	RHC Rehab Hi	4.44
3	RHB Rehab Hi	3.63
4	RHA Rehab Hi	2.79
5	RMC Rehab Med	7.21
6	RMB Rehab Med	4.37
7	RMA Rehab Med	2.93
8	RLB Rehab Lo	3.37
9	RLA Rehab Lo	2.72
10	SE3 Extensive	11.91
11	SE2 Extensive	7.77
12	SE1 Extensive	4.23
13	SSC Special	3.86
14	SSB Special	3.33
15	SSA Special	2.91
16	CD1 Clinically Complex	3.37
17	CC1 Clinically Complex	2.79
18	CB1 Clinically Complex	2.45
19	CA1 Clinically Complex	1.45
20	IB1 Impaired	2.45
21	IA1 Impaired	1.45
22	BB1 Behavior	2.45
23	BA1 Behavior	1.45
24	BV1 Behavior	4.81
25	PE1 Physical	2.79
26	PD1 Physical	2.44
27	PC1 Physical	1.50
28	PB1 Physical	0.85
29	PA1 Physical	0.25

REGULATIONS GOVERNING

THE OPERATION OF

INTERMEDIATE CARE FACILITIES FOR THE

MENTALLY RETARDED

Agency of Human Services
Department of Mental Health
Division of Community Mental Retardation Programs

FINANCIAL STANDARDS

OFFICIAL

7.1 Allowable Costs - Allowable costs are defined as those necessary and ordinary costs related to resident care. They must be costs that prudent and cost-conscious management would pay for a given item or service. It should be noted, however, that allowable costs will not be considered for inclusion in reimbursement rate determination unless they have undergone prior budgetary review and have been approved by the Administrative Agency. The following, although not intended as an all-inclusive listing, are presented as specifics to clarify some anticipated areas of misunderstanding.

7.1.1 Depreciation - Depreciation will be an allowable cost when the following guidelines are followed:

a. Method: straight line.

b. Minimum asset life for new facilities and equipment:

1. Buildings - 25 years.

2. Building improvement - remaining life of building but not less than 15 years.

3. Equipment - 5 years.

4. Vehicles - 3 years.

5. Land improvement - 25 years.

6. Leasehold improvements - the useful life of the improvement or the remaining term of the lease, whichever is shorter.

c. Asset life for used facilities and equipment: reasonable life expectancy.

d. Basis when purchased new: actual cost (which includes legal fees, shipping charges, etc.).

e. Basis when purchased used: actual cost.

f. Basis limitations: all assets with a life expectancy in excess of one year and an individual cost in excess of $500 must be capitalized and depreciated.

7.1.2 Gains and Losses on Disposition of Equipment - Gains and losses on the sale or abandonment of equipment are includable in computing allowable costs. A gain shall be an offset to depreciation expense to the extent that such gain resulted from depreciation reimbursed under these regulations. Gains or losses on trade-ins should be reflected in the basis of the acquired asset.

7.1.3 Costs of Residency - The costs of residence in the facility for administrators and key staff are allowable costs if such costs

together with other compensation, are reasonable.

7.1.4 Cost of Purchases from Related Organizations - The cost of purchases from related organizations are allowable to the extent that they do not exceed the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere, whichever is lower.

7.1.5 Employee Training and Education Costs - Employee training and eucation costs pertaining to providing or improving patient care are allowable.

7.1.6 One Time, Pre-opening Costs of New Facilities - One time, pre-opening costs of new facilities incurred more than seven days prior to admittance of residents are allowable, but must be capitalized and amortized over a period of no less than 35 consecutive months beginning with the month in which the first resident is admitted for care. Examples of these costs are wages paid for services rendered prior to the opening of the facility. Costs related directly to the purchase, construction, or renovation of the building must be depreciated over the life of the building.

7.1.7 Facility Rental Costs - Facility rental costs under sale and lease-back agreements, lease with option to buy arrangements, or agreements with related organizations will be allowable for the lesser of the actual cost or the cost that would have been allowed if the provider owned the facility.

7.1.8 Indirect Costs - Indirect costs which are distributed from other facility cost centers, or, in the case of state owned facilities, from other state agencies and other cost centers of the facility itself, are allowable costs when the basis for such distribution have a statistical basis and have been approved as part of the budgetary process.

7.1.9 Return on Capital Investment - A reasonable rate of return on capital investment will be considered as an allowable cost for proprietary providers. In addition to the budgetary constraints, return on capital will be further limited to a maximum rate per annum as determined by the Administering Agency and applied to that portion of the owner's equity which is used to serve medical assistance residents.

7.2 Non-allowable Costs - Non-allowable costs may be identified in three areas: cost for services not chargeable to the medical assistance program, cost for expenses not related to patient care or costs not actually incurred, and costs that are judged unreasonable by the Administering Agency.

7.2.1 Services Not Chargeable to ICF/MR Medical Assistance Program - Services not chargeable to the ICF/MR Medical Assistance Program include, but are not limited to, the following list (if in establishing a new service, the facility is unable to find the requirement for such service, the Administering Agency should be contacted for an opinion):

a. Education services.

b. Vocational services.

c. Medical services billable under other provisions of the Medical Assistance Program.

d. Services that are specifically funded directly through other sources at least to the extent to which they are funded.

7.2.2 Cost for Expenses not Related to Patient Care - Cost for expenses not related to patient care or costs not actually incurred include, but are not limited to, the following:

a. Depreciation for noted assets.

b. Amortization on intangible assets.

c. Bad debts arising from uncollectable resident accounts.

d. Fund raising.

e. Charitable contributions.

f. Entertainment.

7.2.3 Disallowance - The Administering Agency shall have the right to disallow any costs that relate to management inefficiency and/or unnecessary care of facilities. The cost effect of transactions that are conceived for the purpose of circumventing the regulations contained in this publication will be disallowed under the principle that the substance of the transaction shall prevail over form.

7.3 Rate Limitations - Notwithstanding any other provisions of these regulations, the actual cost rate for residential services will not exceed the provider's normal rate charged private residents of comparable residential services.

7.4 Acceptance of Medical Assistance Rate - The provider must accept the actual cost rates as full and final payment for ICF/MR services delivered to the Medical Assistance client.

7.5 Rate Determination

7.5.1 Budgetary Process

a. Each provider will submit, at least two days prior to the first day of its fiscal year, a budget for the ensuing fiscal year, in the format prescribed by the Administering Agency. This budget will contain line items of expense based on prior year's expenses and allowances for known cost changes as described in Paragraph e. of this section. Each line item must be justified by a concise narrative. For personnel costs, position titles and job descriptions must be used. All projected costs included in the budget which do not meet the criteria of allowable costs as defined in the Allowable Costs section of these regulations, must be deducted in the calculation of net cost.